



Evaluation Report IX: State Maternal & Child Health Early Childhood Comprehensive Systems Grant Program May 2010

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INTRODUCTION

The Indiana State Maternal and Child Health Early Childhood Comprehensive System (ECCS, also referred to as Sunny Start) is an initiative to engage state agencies, community partners, and families of young children to develop a coordinated, comprehensive, community-based system of services for children from birth through age 5. The ECCS reduces duplicated efforts in serving young children and their families while ensuring that services are universally available across the state. The initiative supports access to needed services, fosters the use of appropriate services, and ensures that a system of care supports young children and their families.

Both the strategic plan and the requirements set forth by the Health Resources and Services Administration/Maternal and Child Health Bureau mandate an evaluation of this initiative. The Center for Health Policy (CHP) at Indiana University–Purdue University Indianapolis has worked with the Indiana State Department of Health (ISDH) since June 2006 to develop and execute an evaluation plan. The evaluation focuses

on three areas: the completion and efficacy of activities set forth in the initiative's strategic plan; changes in outcome measures for Indiana families and children; and implementation of the ECCS strategic plan. Where available, data from ISDH and other agencies are used to track changes in outcomes.

This is the ninth evaluation report completed by the Center for Health Policy. The parameters set forth by the ECCS committee for the evaluation were fairly broad in nature; CHP was charged with monitoring the discrete activities of the strategic plan and determining whether or not Indiana families are better off as a result of the ECCS initiative. Further details on the evaluation design are available in the first evaluation report. Data were gathered from the following sources: the Indiana State Department of Health, the Indiana Family and Social Services Administration, Department of Child Services, the United States Census Bureau, and other government entities and private organizations. The most recent data available were included in this evaluation.

THE EARLY CHILDHOOD COMPREHENSIVE SYSTEM INITIATIVE

The ECCS initiative began with a grant from the Health Resources and Services Administration/Maternal and Child Health Bureau on July 1, 2003. The ISDH convened a group of Core Partners, including representatives from state and local agencies and individuals representing service organizations and families. As the steering committee for the ECCS project, Core Partners meet quarterly and are charged with the following tasks:

- educating their organizations on the ECCS initiative's guiding principles
- sharing information on programs impacting children ages birth to 5
- establishing protocols to support communication across agencies and initiatives serving children ages birth to 5.

ECCS Strategic Goals

The Core Partner committee and subcommittees have developed a strategic plan for achieving the goal of coordinated services for children ages birth to 5. The strategic plan encompasses seven primary objectives to realize coordinated and comprehensive services for young children:

- All children in Indiana will have a medical home.
- All children will be covered by a source of payment, either public or private, for medical and developmental services that are identified by the medical home.
- The medical home will facilitate developmental, behavioral, and mental health screening with appropriate treatment referrals to community resources.
- An information clearinghouse will be established to provide resources for families of young children and for providers of early childhood services at both the state and local level.
- Quality resources and supports will be integrated to create a coordinated and accessible early childcare system.

- Parents will have the necessary information, support, and knowledge about child development and will be able to recognize their child's progress.
- Families will have timely access to resources to address their child's health, safety, and developmental needs.

The committee developed a plan for achieving each objective. Further details regarding these objectives, as well as information on the ECCS project's accomplishments to date, can be found at:

<http://www.sunnystart.in.gov>

Year two of the current three-year work plan begins on June 1, 2010. The work plan can be found here:

http://www.in.gov/isdh/files/030409_ECCSSunnyStart_WorkPlanandTimeLine.pdf

Additionally, the evaluation reports and other resource materials can be found at:

<http://www.in.gov/isdh/21192.htm>

Key accomplishments of the ECCS Initiative and its partners to date include:

- the Early Childhood Meeting Place (ECMP) web site
- a developmental calendar for children ages birth to 5
- Paths to QUALITY, a program to educate early childcare providers
- the Zero To Three training program, a program that trains early childhood professionals to promote positive parenting with the goal of eliminating child abuse
- the publication and distribution of a series of 25 Financial Resources Fact Sheets¹ highlighting the financial resources available to Hoosier families
- the Wellness Passport, a personal healthcare record keeping tool for parents
- a comprehensive one-week Summer Institute to help mental health

¹There were 25 Financial Resources Fact Sheets available as of June 7, 2010.



professionals gain expertise in the social and emotional development of young children, infants, and toddlers

These programs are further described within this evaluation.

Recent ECCS Activities

Social and emotional development in young children continues to be a focus of ECCS. The Social and Emotional Consensus Statement, approved by the ECCS Core Partners, is available here:

<http://www.in.gov/isdh/21190.htm>

To help professionals assess the social and emotional competencies addressed by their training, the ECCS committee developed an assessment tool in conjunction with the Consensus Statement.

ECCS sponsored a comprehensive one-week Summer Institute in July 2007 to train child mental health professionals. Furthermore, in August 2008 and again in August 2009, ECCS sponsored training at the Indiana Infant and Toddler Mental Health Annual Conference to help build competencies in the area of social and emotional development.

The Indiana Association for Infant and Toddler Mental Health is offering a 12-hour mentorship course in infant and toddler mental health with support from the ECCS. The courses started in February 2010 and are offered in Noblesville, Columbus, and Vevay. Modules offered include:

- Infant/toddler mental health
- Attachment and ghosts in the nursery
- Sensory, emotional, and behavior regulation
- Trauma, abuse, and affective disorders in young children
- Boundaries, ethics, and culture in working with young children
- Home visits and child care consultation

The Social and Emotional Committee is developing a plan for an infant mental health certificate program, and is currently preparing a course outline and syllabus for each of four planned courses. The first certificate course will be offered in summer of 2011 and the program will be housed in the Social Work Department at IUPUI.

The ECCS Initiative also sponsored a training session entitled “Enhancing Your Work with Young Children and Their Families” at The Institute for Strengthening Families, a seminar held in April 2010 at the Indiana State Government Center. The full-day training session, led by Sarah Martinez, MA, M.Ed., LCPC, focused on how professionals can enhance their work with young children and their families by using a relationship-based approach to intervention. The session also covered techniques for handling difficult situations during home visits and therapy sessions.

The work of the ECCS and its partners was highlighted in two presentations at the Association of Maternal and Child Health Programs’ annual conference, March 6 to March 9, 2010. The Indiana Family Leadership Initiative was one of three programs discussed in a 90-minute workshop titled “The Journey from Families as Consumers to Family Leadership—Cultivating Human Capital to Bring about Systems Change.” The ECCS’s partners from the Indiana Association of Infant and Toddler Mental Health presented a 90-minute workshop entitled “Building Professional Capacity to Meet Infant Mental Health Needs.”

The Family Perspective committee is working to recruit a representative of the Head Start Association and Head Start Collaboration office.



Karen Teliha, director of the Indiana Department of Environmental Management (IDEM), updated Core Partners on the Five Star Environmental Recognition Program for Child Care Providers.² The Five Star program is a voluntary program to help child care providers take simple steps for a cleaner, healthier environment for children. The program is a partnership between IDEM, ISDH, Improving Kids Environment, and Duke Energy. Karen reported on Five Star's recent "no idling" initiative.³ No idling signs were distributed to members and applicants to the Five Star program. Approximately 150 signs have been distributed to date thanks to financial assistance from Duke Energy. Karen reported that the signs have lead to an 84% reduction in idling at participating child care facilities. Reduced idling leads to decreased air pollution and is especially helpful to people who have asthma or other respiratory conditions.

The Family Leadership Initiative was launched in August 2008. The project has been supported by both the ECCS and the

Riley Child Development Center. The Family Leadership Initiative aims to strengthen and support leadership development within Indiana families. The initiative is not focused on providing support for families, but rather on providing leadership development for families interested in taking an active role in policy advocacy and serving on committees and task forces. The initiative seeks to create a structure to guide parents through their leadership development journey.

The Family Leadership Initiative has created a set of leadership competencies and a portfolio approach to track leadership development. There are four competency areas: family-provider partnerships, cultural proficiency, delivery and support systems, and advocacy. Each competency has three levels: leadership in the family, leadership at the local level, and leadership at the state and/or national level. The portfolio provides a tool for individuals to track the experiences and trainings which demonstrate their competencies.

²The Five Star Childcare web site is located at: <http://www.in.gov/idem/4180.htm>

³A flyer for the "no idling" program is available here: http://www.in.gov/idem/files/5star_no_idle.pdf

INSURANCE COVERAGE AND ACCESS

This section addresses insurance coverage and healthcare access for children 5 and younger in Indiana. Areas addressed are:

- medical home and Community Integrated Systems of Service
- the Wellness Passport, an electronic medical record
- Care Select
- source of payment for healthcare
- Medicaid, Hoosier Healthwise, and SCHIP enrollment and service use
- Early and Periodic Screening, Diagnosis, and Treatment
- programs for children with special healthcare needs

Medical Home and Community Integrated Systems of Services

A main goal of this initiative is to ensure that all children have access to healthcare services. To facilitate achievement of this goal, the ECCS program advocates the medical home concept.

A medical home provides a consistent point of entry to the medical system through a primary care physician or a team of caregivers. Prior research has shown that the comprehensiveness and coordination of care offered by a medical home improves health outcomes and reduces disparities in the use of health services (Starfield & Shi, 2004). The National Survey of Children's Health reports that in 2007 70.3 percent of Indiana children aged birth through 5 had a medical home, an increase from the 61.6 percent of Indiana children in the same age group who had a medical home in 2003. Nationally, 64.0 percent of children aged birth through five had a medical home in 2007, a rate slightly below that in Indiana.

The ISDH received a grant from the federal Maternal and Child Health Bureau to develop the Community Integrated

Systems of Services for Children and Youth with Special Health Care Needs (IN CISS). Developing the medical home concept in Indiana is a major objective of the IN CISS project. The IN CISS Medical Home subcommittee and the ECCS Medical Home workgroup have been combined because many of the same people were involved in both groups.

The IN CISS project holds weekly planning meetings with a core group of partners. Three contracts have been initiated to support the project. The first, with the IU School of Medicine, is to provide a project facilitator, parent consultants, and project evaluator. The second, with the Center for Youth and Adults with Conditions of Childhood, is for the development of a website and for educational office visits to help youth with special healthcare needs transition to adult healthcare. Finally, About Special Kids was contracted to provide meeting support, stipends for families and youth, and other support.

The IN CISS project has recruited 12 healthcare practices to participate in a Medical Home Learning Collaborative. This project will aid the 12 practices in developing and implementing quality improvement efforts to aid with the implementation of the medical home concept. Nine of the 12 teams have agreed to participate in biweekly conference calls, covering topics like use of brochures to indicate a practice is a medical home and awareness of billing codes that support medical homes. Site visits have been scheduled for all practices and were started in the spring of 2010. Teams also participate in annual meetings over the three years of the grant.

Dr. Nancy Swigonski has been hired to lead the Medical Home Learning Collaborative. Dr. Swigonski is a member



of the faculty of General and Community Pediatrics and Public Health at the Indiana University School of Medicine and has served on the American Academy of Pediatrics' Medical Home Initiative Project Advisory Committee. Dr. Swigonski will oversee the operation of the collaborative. Two parent liaisons have also been hired and are responsible for interacting with the participating practices, providing practice resources, mentoring family partners, aiding the development of agendas, scheduling site visits, and collecting data.

Wellness Passport

The Family Advisory Committee, along with the Maternal and Child Health Division, developed the Wellness Passport as a tool to help parents and caregivers track their child's medical information in an electronic format that can be easily shared with their medical providers. The Wellness Passport is available for download from the ECMP web site (<http://earlychildhoodmeetingplace.indiana.edu/>). Families can also call the Indiana Family Helpline to request the Wellness Passport on a free flash drive or on paper.⁴ The web site and flash drive versions are accompanied by a narrated PowerPoint file that introduces the user to the Wellness Passport and other products from the ECCS Initiative. These additional products, such as the ECCS Financial Resources Fact Sheets and the developmental calendar, are also included on the flash drive and are downloadable off the ECMP web site.

A Special Health Care Needs Addendum is available for families whose children have more complex healthcare needs that necessitate recording more specialized medical information. The Wellness Passport and the Addendum are both also available in Spanish.

Care Select Program

Indiana's care management program, Indiana Care Select, serves several populations, including the blind, physically and mentally disabled, wards and foster children, and children receiving adoption services. The Office of Medicaid Policy and Planning (OMPP) contracts with care management organizations that are responsible for coordinating healthcare for Care Select enrollees.

Care Select is a primary care case management program designed to tailor healthcare benefits to the individual, improve quality of care and health outcomes, and provide a holistic approach to member's health needs. Care Select members are linked to a primary medical provider (PMP), with reimbursement available for care management conferences in keeping with the medical home model.

In addition to facilitating a medical home for each member by assigning each a PMP, *Care Select* ensures access to care through care coordination. Care coordination is performed by a multidisciplinary team of care managers, including healthcare professionals such as nurses, social workers, and physicians. This team involves members in their own healthcare by developing individually tailored care plans. The plans take into consideration a member's healthcare needs and personal goals toward improved functional status, improved clinical status, and enhanced quality of life, as well as member satisfaction, adherence to treatment or care plans, improved member safety, and member autonomy. Care coordination involves collaboration with multiple providers in all care settings, including home, clinic, and hospital.

Since its inception, the *Care Select* program's enrollment has increased

⁴Indiana Family Helpline: 1-800-433-0746



steadily. Implementation consisted of a three-phase rollout, with central region enrollment in November 2007, statewide enrollment in March 2008, and ward and foster children enrollment in July 2008. By December 2008, OMPP data showed that there were 4,726 children from birth to age 5 enrolled, and enrollment has increased to 7,358 in April 2010.

Sources of Payment for Healthcare

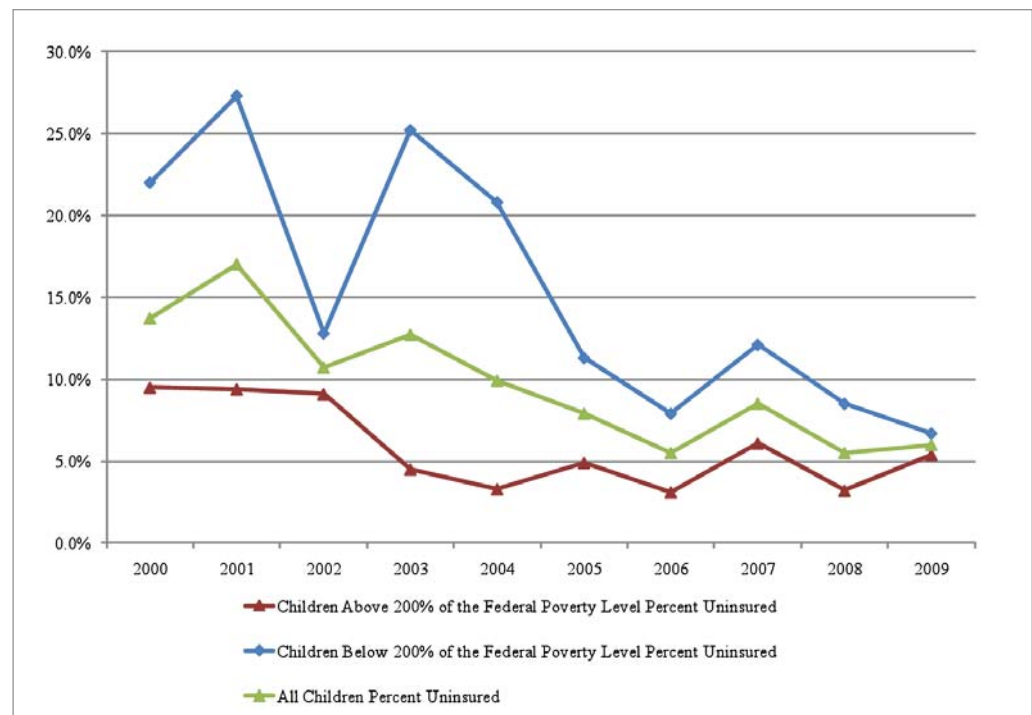
One of the greatest barriers to healthcare access is the inability to pay. Research confirms disparities in the use of primary care between insured children and uninsured children (P. Newacheck, D. Hughes, & J. Stoddard, 1996; Newacheck, Stoddard, Hughes, & Pearl, 1998; Stevens, Seid, & Halfon, 2006) Children with no healthcare coverage are significantly less likely to have a regular source of care and to consistently see the same physician. Furthermore, uninsured children are more likely to be inadequately vaccinated and have fewer annual physician visits (P. W.

Newacheck, D. C. Hughes, & J. J. Stoddard, 1996). The ECCS initiative seeks to eliminate this disparity by promoting healthcare access for all Indiana children.

To monitor progress toward this objective, CHP used data from the United States Census Bureau's *Current Population Survey—Annual Social and Economic Supplement* to estimate the number of uninsured children below 200 percent of the federal poverty level (FPL), as well as the total number of uninsured children age 5 or younger (see Figure 1).

The FPL, as determined by the Department of Health and Human Services, plays an important role in determining how Hoosier children receive health coverage. The FPL is the minimum income that a family needs in order to sustain living expenses. The FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines.

Figure 1: Percent of Uninsured Children (5 and Younger) in Indiana



Source: US Census



As of March 2009, an estimated 522,233 children age 5 or younger lived in the state of Indiana, 31,579 (6.0 percent) of whom were not covered by any type of health insurance. Furthermore, 251,420 (48.1 percent) of children ages 5 or younger in Indiana lived in a household below 200 percent of the FPL, 16,842 (6.7 percent) of whom lacked any form of health coverage (U.S. Census Bureau, 2009). Only 5.4 percent of children ages 5 or younger living in households above 200 percent FPL lacked health insurance.

Families USA reports that 48.2 percent of Indiana's uninsured children of all ages come from low-income (below 200 percent FPL) families who are likely eligible for Hoosier Healthwise. Furthermore, the Families USA report finds that despite the lower rate of insurance in low-income families, the majority of uninsured children (of all ages) in Indiana come from families living above 200 percent FPL (Families USA, 2008).

Medicaid, Hoosier Healthwise, and SCHIP Enrollment and Use

Low-income children are less likely to be covered by healthcare and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is

of paramount concern for our nation and has led to national coverage programs for children. Healthcare financing sources for low-income and disabled children include Medicaid and SCHIP funding, both of which are administered in Indiana through the following programs: Hoosier Healthwise, a risk-based managed care (RBMC) program; Care Select; and fee-for-service Medicaid programs.

Public assistance programs like Medicaid define eligibility income limits as a percentage of FPL. Medicaid and SCHIP use family income and/or asset limitations to determine eligibility and type of coverage, as follows:

- Low-income families, children under the age of 18 living with low-income parent(s) or other caretaker relative, and young adults (18, 19, and 20 years old) who live with a caretaker relative may be eligible for premium-free coverage (Medicaid).
- SCHIP provides low-cost health coverage to children 19 years old and younger with family incomes of no more than 150 percent of the FPL.
- Additional SCHIP (Package C) benefits are available to children in families whose income is 151 to 250 percent of the FPL (see Table 1). Premium amounts for Package C are between \$22 and \$70 per month, based on family income and the number of family members covered.

Table 1: SCHIP Package C Premium Rates

Family FPL	Monthly Premium for 1 Child	Monthly Premium for 2 or More Children
151% up to 175%	\$22	\$33
175% up to 200%	\$33	\$50
200% up to 225%	\$42	\$53
225% up to 250%	\$53	\$70



The data included in this report are based on administrative claims, likely representing an underestimate of actual use due to claims processing practices. Data from the OMPP indicates that a total of 295,221 children ages 5 and younger were enrolled in Indiana Medicaid programs at the end of State Fiscal Year (SFY) 2008.⁵ The 2008 figures demonstrate an upward trend in enrollment, as compared to the SFY 2007 total of 287,810 children ages 5 and younger enrolled in Medicaid programs (see Table 2).

Indiana's SCHIP program is seamlessly integrated into Hoosier Healthwise. As such, SCHIP enrollees have the same access to providers as all other Medicaid managed care members, including choice of PMP. Children enrolled in the *Care Select* Program and fee-for service Medicaid are also included in this reported data.

Table 2 provides a comparison across two years of enrollment and claims data. Of the 295,221 children enrolled at some point during SFY 2008, the state reports that 274,145 (93%) were covered by a plan

with capitated (fee per patient) payments to Hoosier Healthwise, an RBMC delivery system.⁶

The number of children from birth to 5 years of age enrolled in Hoosier Healthwise increased during SFY 2008. Along with the additional enrollment of children, it's evident that a higher percentage of children in this age range are undergoing medical treatment, with a significant rise in the number seeing a PMP in SFY 2008. The data also suggests a slight decline in the use of clinic and hospital settings in SFY 2008.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of performance measures. HEDIS® measures address a broad range of health issues, including children's access to preventive/ambulatory care. Table 3 indicates 2007/2008 rates for this measure, along with the respective HEDIS® benchmarks. Collectively, Hoosier Healthwise HEDIS® rates measured just below the 50th percentile for the measure of children's access to preventive/ambulatory care.

⁶Some of the Medicaid managed care programs in Indiana provide a capitation (fee per patient) payment to a managed care organization (MCO), which is then responsible for arranging, providing, and paying for the services of its members as designated by the OMPP.

⁷Encounter claims data indicated that any type of Medical Provider encompassed an extensive list of provider types, including specialist, advanced practice, and mental health.

⁸Primary Medical Provider (PMP) is described as one of the following: 316 – Family Practitioner; 318 – General Practitioner; 328 – OB/GYN; 344 – General Internist; 345 – General Pediatrician; 315 – Emergency Medicine Practitioner; and 323 – Neonatologist.

⁹Clinic setting is defined as 080 – Federally Qualified Health Clinics (FQHC); 081 – Rural Health Clinics (RHC); and 082 – Medical Clinics.

¹⁰Hospital settings include ER/Outpatient visits.

Table 2: State Fiscal Year 2007 and 2008 Enrollment, Children Birth to 5 Years of Age

	2007	2008
Total Enrollment	287,810	295,221
Hoosier Healthwise	265,971 (92%)	274,145 (93%)
Care Select and Fee-For-Service	21,839 (8%)	21,076 (7%)
Visiting Any Type of Medical Provider ⁷ (all programs)	226,804 (79%)	260,656 (88%)
Seen by Primary Medical Provider (PMP) ⁸ (all programs)	158,191 (55%)	189,457 (64%)
Seen in a Clinic ⁹ setting (all programs)	114,042 (40%)	113,852 (38%)
Seen in an outpatient hospital ¹⁰ setting (all programs)	98,975 (35%)	98,344 (33%)



Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

All children from birth to 21 years of age enrolled in Medicaid or SCHIP are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This program offers prevention-oriented services designed to assess health and development, vision, dental, and hearing in an effort to identify and treat conditions that may impede natural growth. In addition to screening services, EPSDT encompasses diagnostic and treatment services for children birth through 21 years of age.

Medical Services

The EPSDT Participation Report provides data to the Center for Medicare and Medicaid Services (CMS). CMS reporting requirements require Medicaid and

SCHIP enrollee data to be reported on separate Participation Reports. EPSDT participation is reported by federal fiscal year (FFY), defined as October 1 through September 30. Table 4 demonstrates the comparison between Medicaid- and SCHIP-eligible people receiving EPSDT services in FFY 2007 and FFY 2008.

The state's periodicity schedule specifies the total number of initial or periodic general health screenings required to be provided. The periodicity schedule used in Indiana reflects American Academy of Pediatrics recommendations, along with those of the Hoosier Healthwise Clinical Advisory Committee, and is meant to be a guide for Indiana Medicaid providers participating in the EPSDT program. Reported data is based on a total of 14 screenings recommended from birth through 5 years of age.

Table 3: Children's Access to Preventive/Ambulatory Care

Age Group	2007	2008	HEDIS® Medicaid Managed Care 50th Percentile
12 to 24 months	94.9%	94.2%	95.8%
25 months to 6 years	84.3%	85.0%	86.5%

Table 4: EPSDT Participation Report: Initial or Periodic Screening Services, Federal Fiscal Year 2007 and 2008

	Medicaid		SCHIP	
	2007	2008	2007	2008
Enrollment, All Programs ¹¹	256,395	263,340	11,428	10,278
Total Eligibles Receiving at Least One Initial or Periodic Screen	201,118 (78%)	203,898 (77%)	7,956 (68%)	7,019 (68%)

¹¹EPSDT reports are based on Federal Fiscal Year enrollment, defined as October 1st through September 30th. Children enrolled in Medicaid or SCHIP for any portion of the year are counted in the respective report for the time period in which they were enrolled.



Dental Services

Oral health is too often overlooked in this very young population, even when dental care is critical. Medicaid-eligible children receiving dental care are documented in the EPSDT Participation Report. Table 5 displays a side-by-side comparison of the dental services reported for FFY 2007 and FFY 2008.

OMPP has placed special emphasis on primary care and dental services, having established pay-for-performance measures for well-child, adolescent, and dental visits during the 2009–2010 contract years for Hoosier Healthwise and Care Select. Further measures to engage providers in EPSDT programs are a cornerstone of the state's 2009–2010 Quality Strategy.

Children with Special Healthcare Needs

Access to care is particularly important for children with special healthcare needs. The ISDH Children's Special Health Care Services (CSHCS) provides supplemental medical coverage to families of children ages birth to 21 years of age with serious, chronic medical conditions that have lasted or may be expected to last at least two years. A family is financially eligible if they have an income below 185% of the FPL. Families with an income between

185% and 250% of the FPL are eligible so long as there are sufficient funds to cover all CSHCS's enrollees from families below 185% FPL. More information regarding the Children's Special Health Care Services can be found on their website (<http://www.in.gov/isdh/19613.htm>).

The number of children enrolled in the ISDH Children's Special Health Care Services (CSHCS) program serves as an additional measure of healthcare access. In 2008, a total of 2,624 children ages 5 and younger participated in the CSHCS program (see Figure 2). This represents one percent of the population ages 5 and younger, a decrease of 42 percent from the 4,538 children enrolled during 2002 (Indiana State Department of Health, 2009).

Two changes are responsible for the decreased enrollment in CSHCS. First, prior to 2001 CSHCS had care coordinators working in the local communities. These coordinators performed home visits and helped parents fill out applications for their children. Second, beginning in 2006, CSHCS began to focus on case management, with a yearly reevaluation of medical and financial eligibility. Both of these changes have resulted in declines in the number of children enrolled in CSHCS.

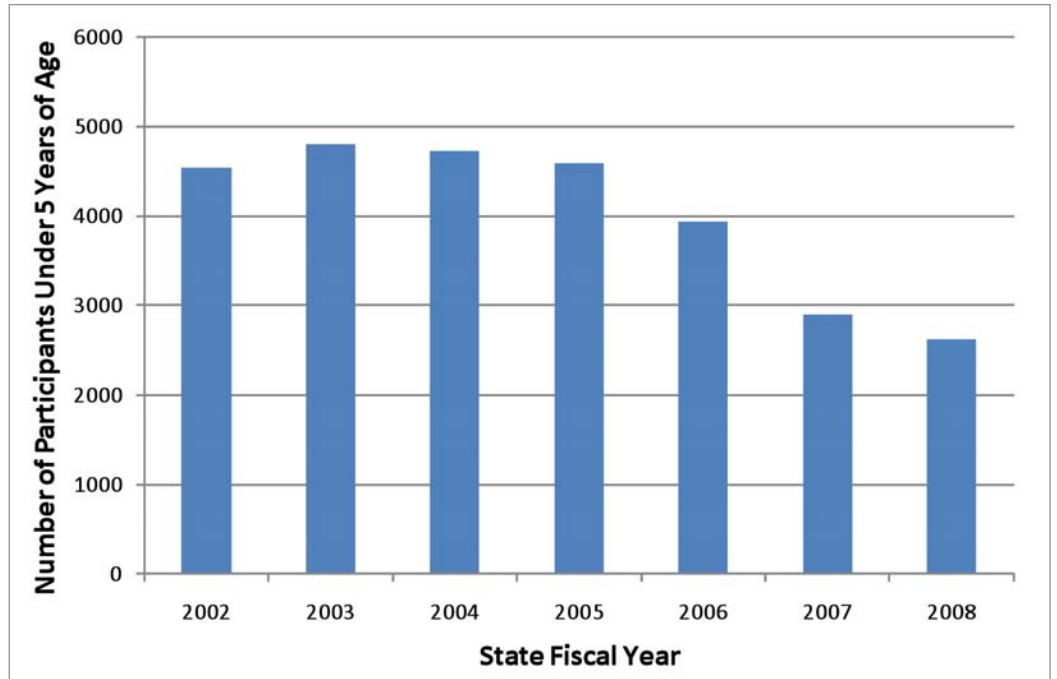
Table 5: EPSDT Participation Report: Dental Services, Federal Fiscal Year 2007 and 2008

	Medicaid		SCHIP	
	2007	2008	2007	2008
Enrollment, All Programs ¹²	256,395	263,340	11,428	10,278
Total Eligibles Receiving Any Dental Services	25% (65,046)	26% (67,778)	28% (3,210)	31% (3,203)
Total Eligibles Receiving Preventive Dental Services	22% (57,508)	24% (62,481)	25% (2,839)	28% (2,875)
Total Eligibles Receiving Dental Treatment Services	9% (23,530)	9% (23,910)	9% (1,024)	9% (918)

¹²EPSDT reports are based on FFY enrollment, defined as October 1 through September 30. Children enrolled in Medicaid or SCHIP for any portion of the year are counted in the respective report for the time period in which they were enrolled.



Figure 2: Children with Special Healthcare Needs: Total Number of Participants Ages 5 and Under



Source: Indiana State Department of Health

Identifying and Treating Children with Disabilities

Identification of children with developmental, behavioral, and mental health needs is another component of high quality continuous care. The establishment of a medical home for young children, particularly through the Community Integrated Systems of Services project, will increase the likelihood that care providers will

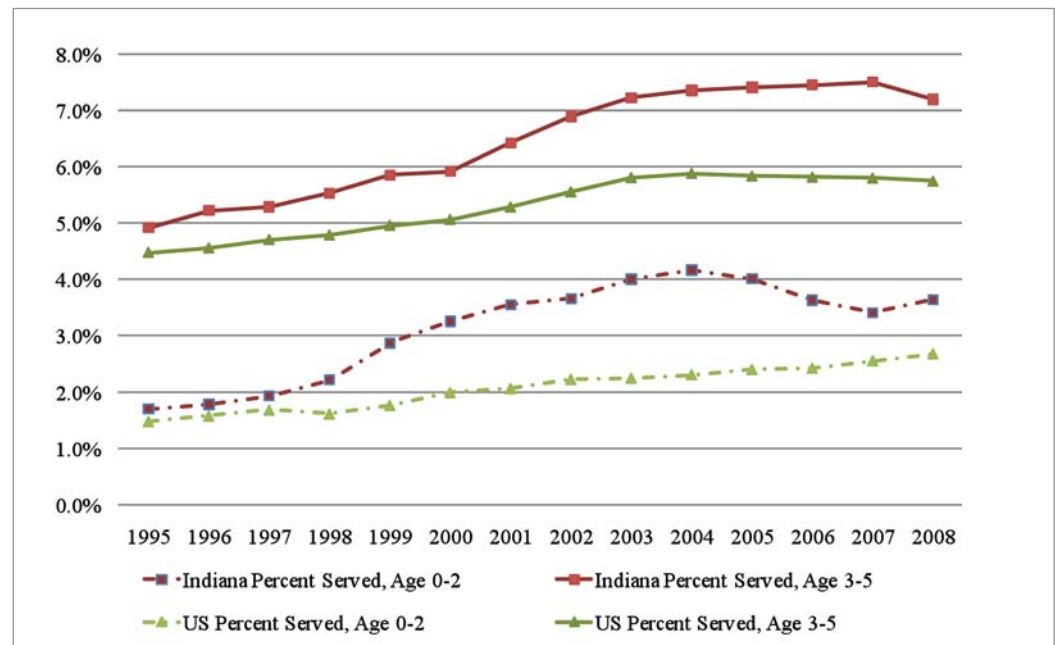
recognize symptoms early through the use of screening tools, and will also aid physicians in providing comprehensive and coordinated services. Research indicates that this type of coordination improves the quality of life for young children identified as needing developmental, behavioral, and mental health services—children who may not have received treatment prior to ECCS (American Academy of Pediatrics Committee on Children with Disabilities, 2001).



The Individuals with Disabilities Education Act (IDEA) supports healthcare access for children with disabilities. The IDEA Program served 28,590 Hoosier children ages 5 and under on December 1, 2008. Of these children, 18,834 were between the ages of 3 and 5, representing an increase of 54 percent since 1995. The remaining 9,756 children, ages 2 and younger, were provided services through the Early Intervention Program for Infants

and Toddlers with Disabilities coordinated by First Steps, representing an increase of 133 percent since December 1, 1995. In contrast to the number of children ages 3 to 5, the number of children 2 and younger who were served peaked at 10,738 (4.1 percent of all children 2 and younger) on December 1, 2004, and has since decreased. However, the percentage of children 2 and younger served by IDEA remains above the 1995 level (see Figure 3).

Figure 3: Percentage of Hoosier Children (Ages 0 to 2 and Ages 3 to 5) Served by IDEA



Source: IDEA Data Website

Several outcome measures related to the goals of the ECCS Initiative are evaluated here. These include:

- immunization rates
- infant and child mortality
- child neglect and abuse
- teen pregnancy

Immunization Rates

Along with evaluating medical visits, one way to measure trends in the wellbeing of children is to investigate the immunization rates of young children. To be considered completely immunized by the ISDH, a child must have received age-appropriate vaccines for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus influenzae type b, pneumococcus, and chickenpox.

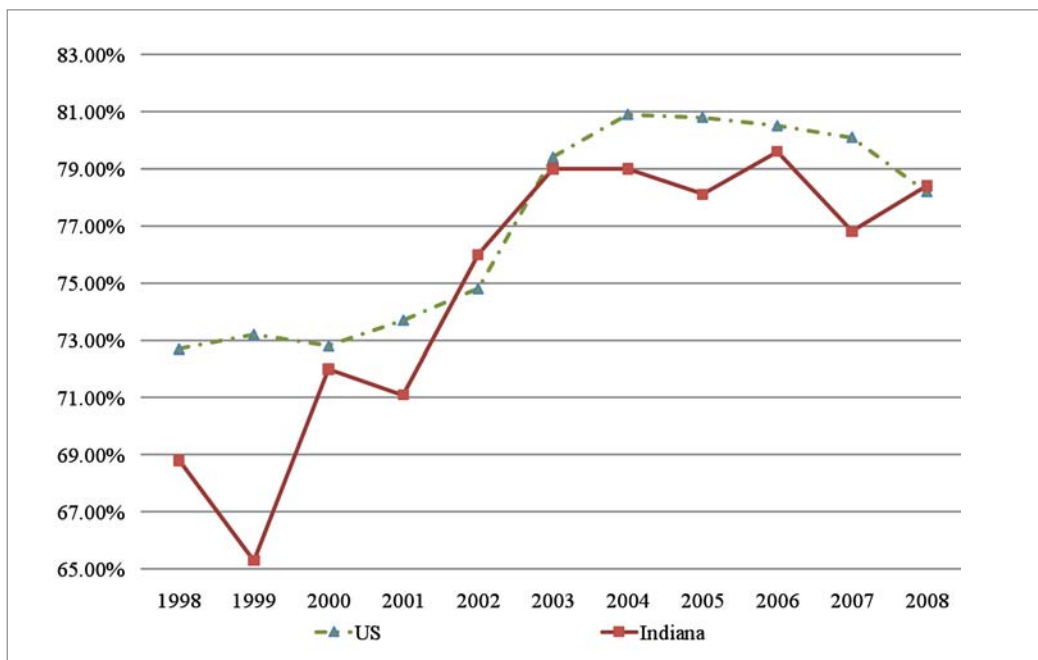
ISDH data for 2004–2005 indicate that of those children enrolled in a licensed childcare center, 77 percent of children ages 15 to 23 months and 83 percent of

children ages 2 to 5 received complete vaccines (Indiana State Department of Health, 2005).

Additionally, 94 percent of children enrolling in kindergarten, 96 percent of children enrolling in first grade, and 98 percent of children enrolling in sixth grade at reporting Indiana schools during 2006–2007 were fully vaccinated (Indiana State Department of Health, 2008).

The National Immunization Survey, conducted for the Centers for Disease Control by the National Opinion Research Center at the University of Chicago, provides an additional measure of immunization (see Figure 4). Data from the National Immunization Survey show that 78.4 percent of Indiana children ages 19 to 35 months were immunized in 2008 compared to a national rate of 78.2 percent (U.S. Department of Health and Human Services (DHHS). National Center for Health Statistics, 2008).

Figure 4: Immunization Rates for Children 19 to 35 Months of Age (4:3:1:3:3 Combined Series)¹³



Source: Center for Disease Control

¹³ Immunization in this case refers to children who received the 4:3:1:3:3 combined series that includes four or more doses of diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, or diphtheria and tetanus toxoids and acellular pertussis vaccine; three or more doses of any poliovirus vaccine; one or more doses of a measles containing vaccine; three or more doses of Haemophilus influenzae type b vaccine; and three or more doses of hepatitis B vaccine.



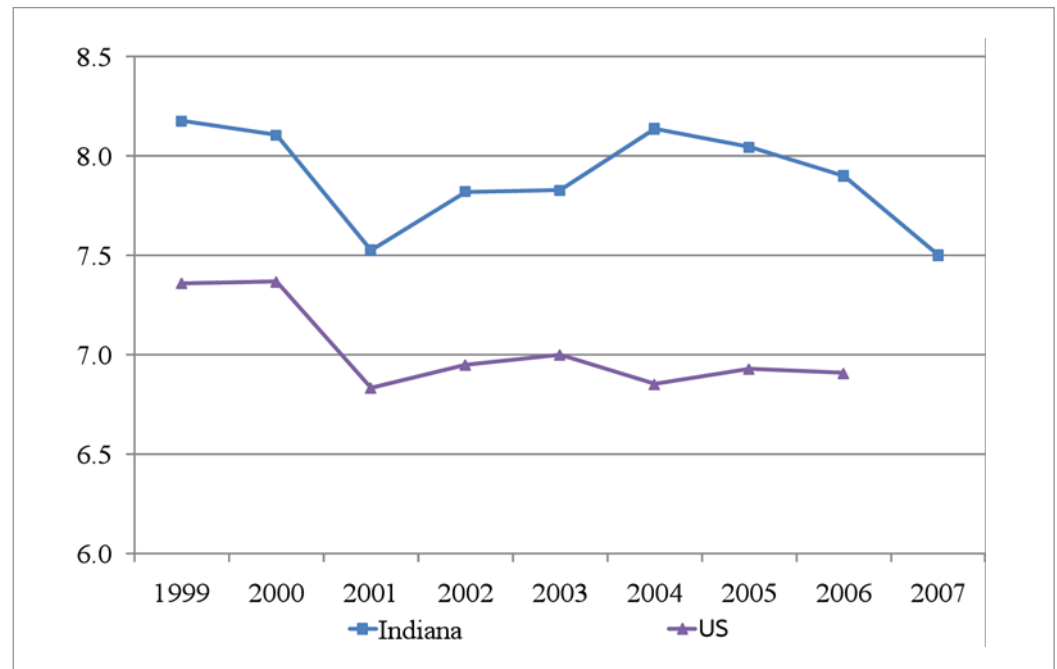
Infant and Child Mortality Rates

The 2006 infant mortality rate (for children under 1 year of age) in Indiana was 7.9 deaths per 1,000 (Centers for Disease Control and Prevention, 2009a). The nationwide infant mortality rate was 6.9 deaths per 1,000 (see Figure 5a). In 2007 the rate in Indiana had decreased to 7.5. The 2007 infant mortality rate is not yet available for the nation. The infant mortality rate in Indiana has consistently been higher than the rate for the nation

and has followed a trend similar to that of the nation as a whole.

The infant mortality rate in Indiana varies significantly by race. The mortality rate for black infants (15.7 infants per 1,000 in 2007) has been markedly higher than that for white infants (6.5 per 1,000 in 2007). Alarming, the rate for black infants has increased nearly every year since 2001, with a 2007 decrease the only exception (see Figure 5b).

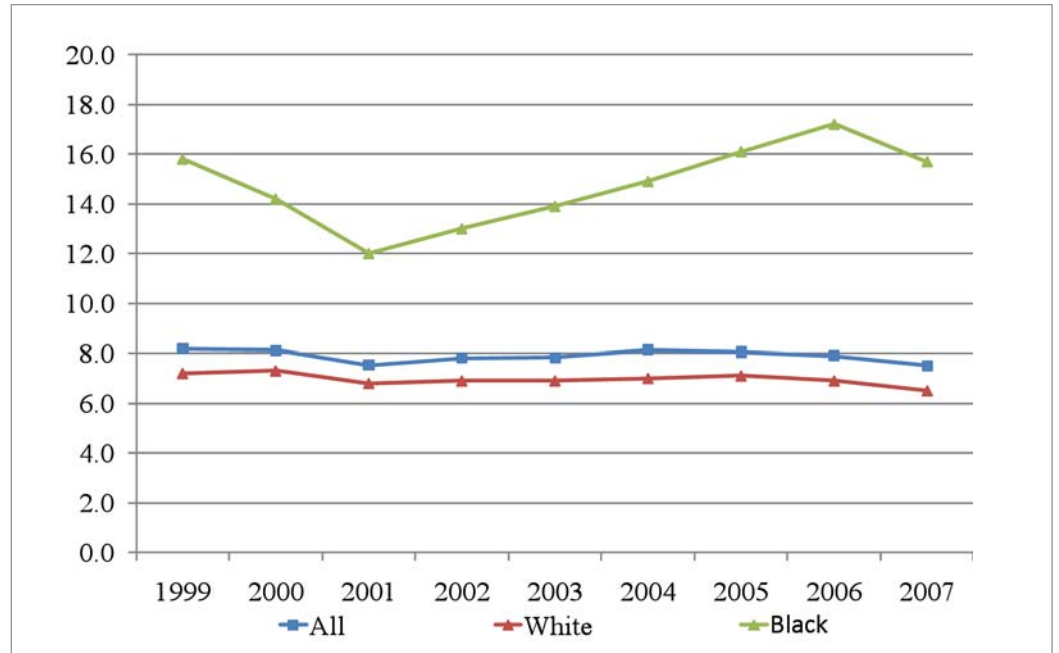
Figure 5a: Infant Mortality Rate: Indiana versus US (per 1,000 Children Under 1 Year of Age)



Source: CDC, ISDH



Figure 5b: Infant Mortality Rate: Indiana by Race (per 1,000 Children Under 1 Year of Age)

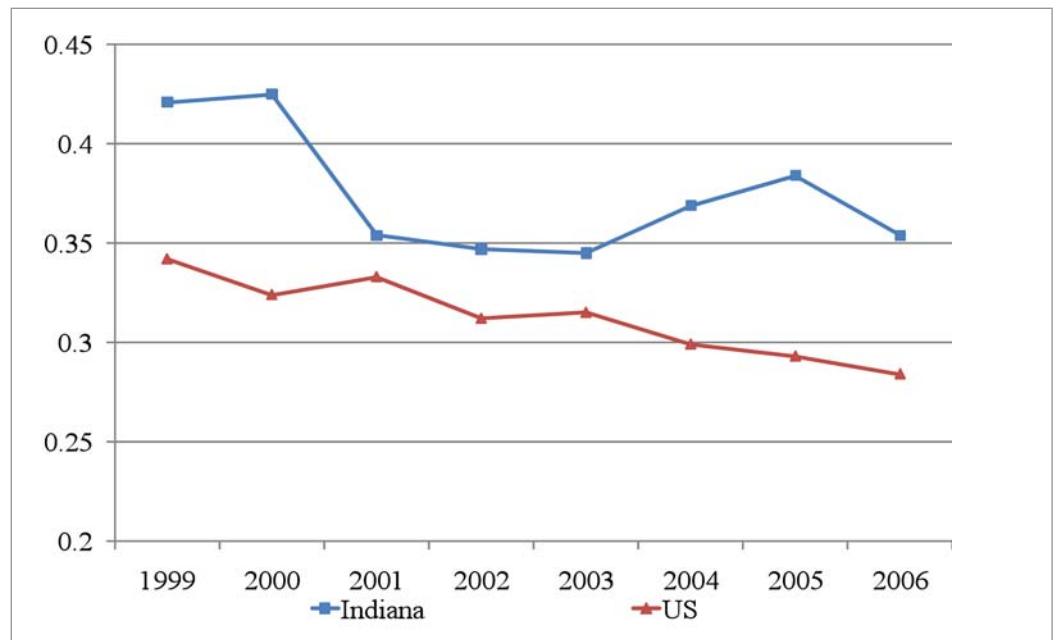


Source: CDC, ISDH

In 2006, the mortality rate for Indiana children 1 to 4 years of age was 0.35 per 1,000, compared to a rate of 0.28 per 1,000 for the United States (see Figure 6). The

rate in Indiana is higher than for the nation; the gap between the two has fluctuated over the past 15 years.

Figure 6: Child Mortality Rate (per 1,000 Children Ages 1 to 4 years)



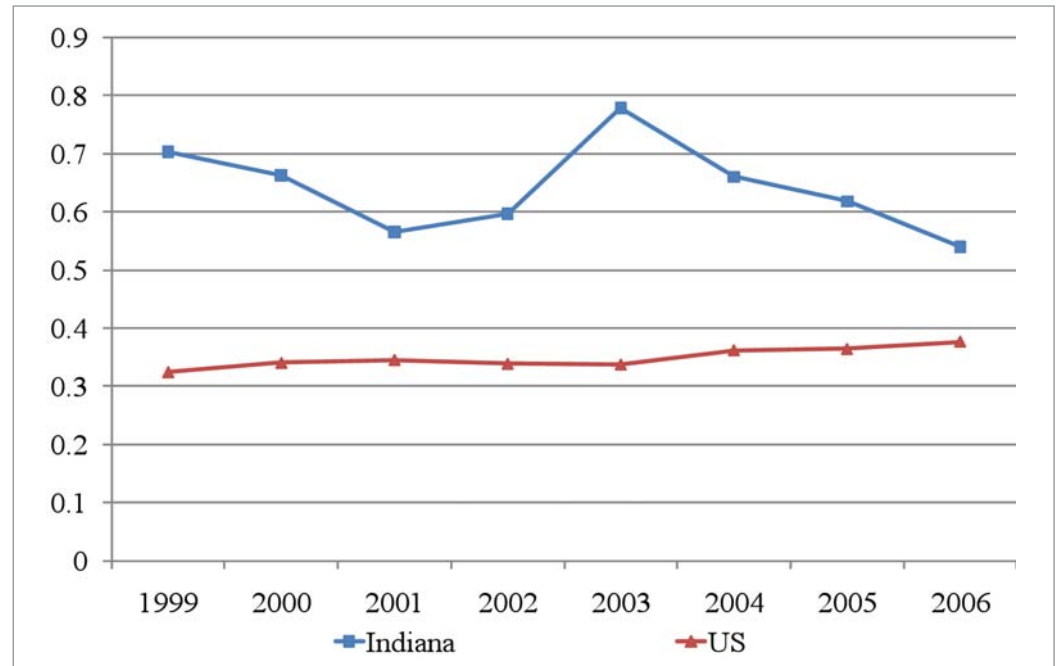
Source: CDC



The injury mortality rate in 2006 for infants under 1 year of age was 0.54 per 1,000, compared to a national rate of 0.38 per 1,000 (see Figure 7). Injury deaths include unintentional injuries, violence-related injuries (homicide, legal intervention, and suicide), as well as

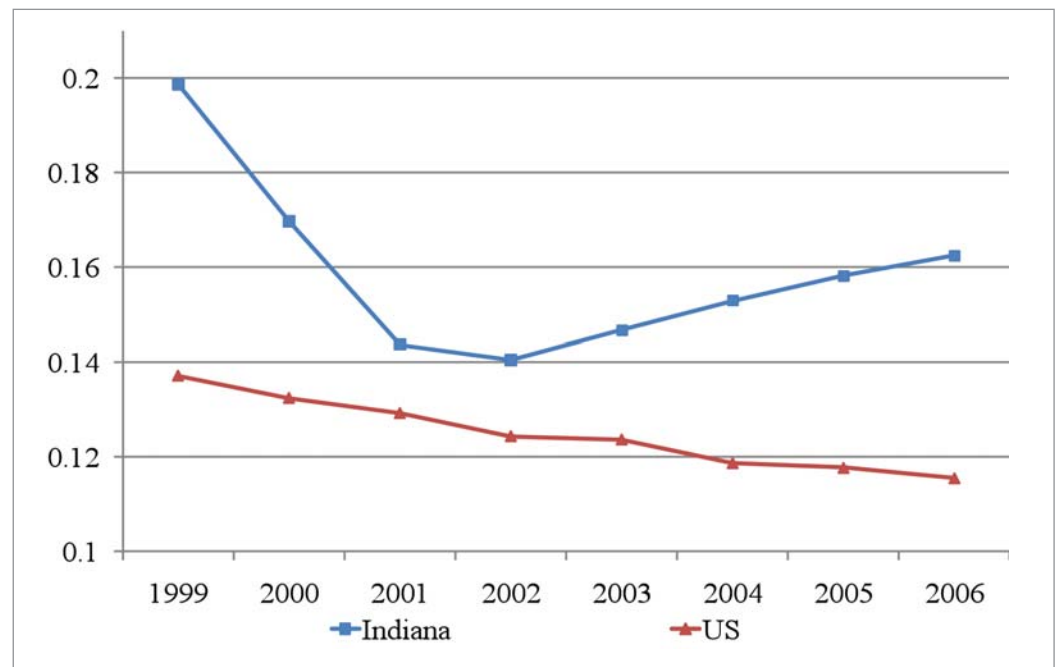
injuries in which the intent was undetermined (Centers for Disease Control and Prevention, 2009b). The injury mortality rate in 2006 for children ages 1 to 4 was 0.16 per 1,000, compared to a national rate of 0.12 per 1,000 (see Figure 8).

Figure 7: Infant Injury Mortality Rate (per 1,000 Children Under 1 Year of Age)



Source: CDC

Figure 8: Child Injury Mortality Rate (per 1,000 Children Ages 1 to 4)



Source: CDC



Child Neglect and Abuse

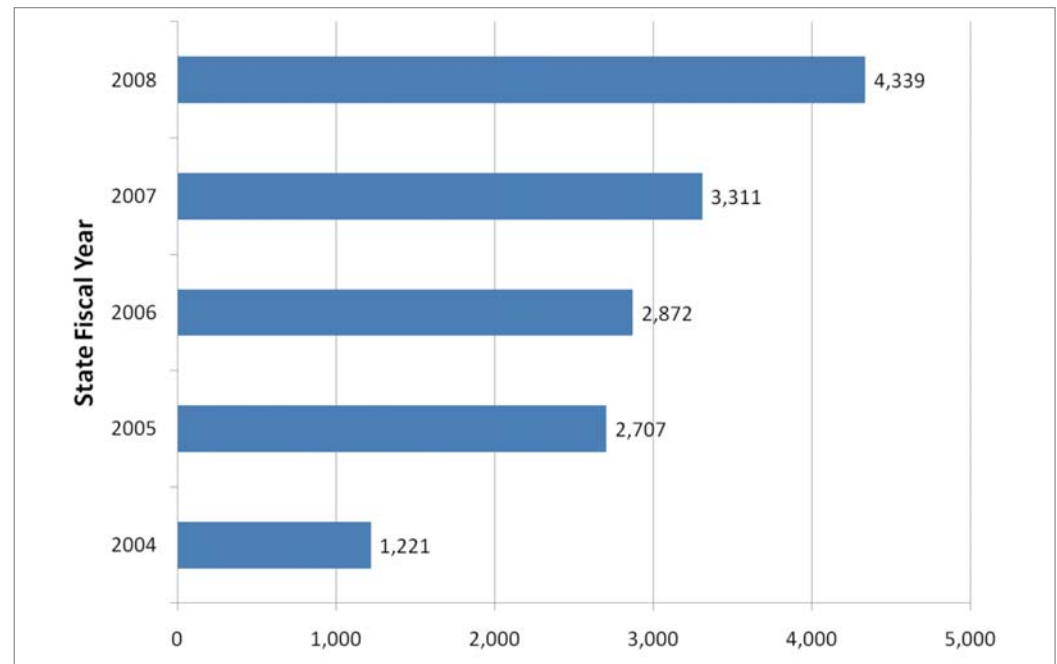
An additional measure of childhood wellbeing is the number of children reported as abused or neglected. During state fiscal year 2008, 4,339 children ages 5 and under were abused and/or neglected and consequently declared a child in need of services (CHINS), as shown in Figure 9. This figure represents approximately 0.8 percent of children under age 5 in Indiana who were reported as being abused or neglected during 2008.

The number of CHINS has increased significantly since 2004; however, this does not indicate that the welfare of children is worsening in Indiana. The Department of Child Services (DCS) was established in January 2005 by executive order of the governor. The creation of this department and the governor's emphasis on protecting children have almost certainly led to a higher rate of identification of children in need of services,

accounting for some of the increase in CHINS from 2004 onward. During 2006, a total of 53 child fatalities were due to abuse and neglect, of which 66 percent were children 0 to 3 years of age.

Healthy Families Indiana is a voluntary home visitation program that promotes health in families and children through child development, access to health care, and parent education. Healthy Families Indiana works closely with hospitals, prenatal clinics, and local agencies to identify families that could benefit from their services. The program aims to reduce child abuse and neglect as well as childhood health issues and juvenile delinquency. Last Fall DCS received a cut in TANF funds of \$20 million. This translated into a \$10 million cut for Healthy Families because DCS was able to secure one time SSBG funding of \$10 million. DCS spread this cut across three years at \$3.3 million per year.

Figure 9: Number of Children (Ages 5 and Younger) Declared a Child in Need of Services, by State Fiscal Year



Source: Indiana Department of Child Services



DCS, along with other state agencies, was then asked to reduce its budget by 10%, a total reduction of more than \$60 million. Internally, over the past year, DCS has cut staff positions totaling more than \$2.8 million and made cuts to overtime allowances, communication costs, and travel allowances and reimbursements.

These additional budget cuts meant additional reductions to the Healthy Families contracts. Beginning January 1, 2010, the State funding for HFI was eliminated.

The Zero to Three training program educates childcare professionals with the goal of reducing child abuse. ECCS, the Indiana State Head Start Collaboration Office, and Healthy Families Indiana provided funding to purchase curricula and other materials used to instruct 38 trainers from throughout Indiana. The initial training occurred in April 2008 as part of the Healthy Families Indiana three-day conference. This training has produced a statewide, specialized group of individuals who help the childcare community understand their role in the prevention of child abuse. Those individuals who have completed the training are now qualified to instruct others. A total of 38 trainers provide instruction statewide. To date, these trainers have provided 190 hours of training to a total of 1,748 primary childcare providers.

Teen Pregnancy

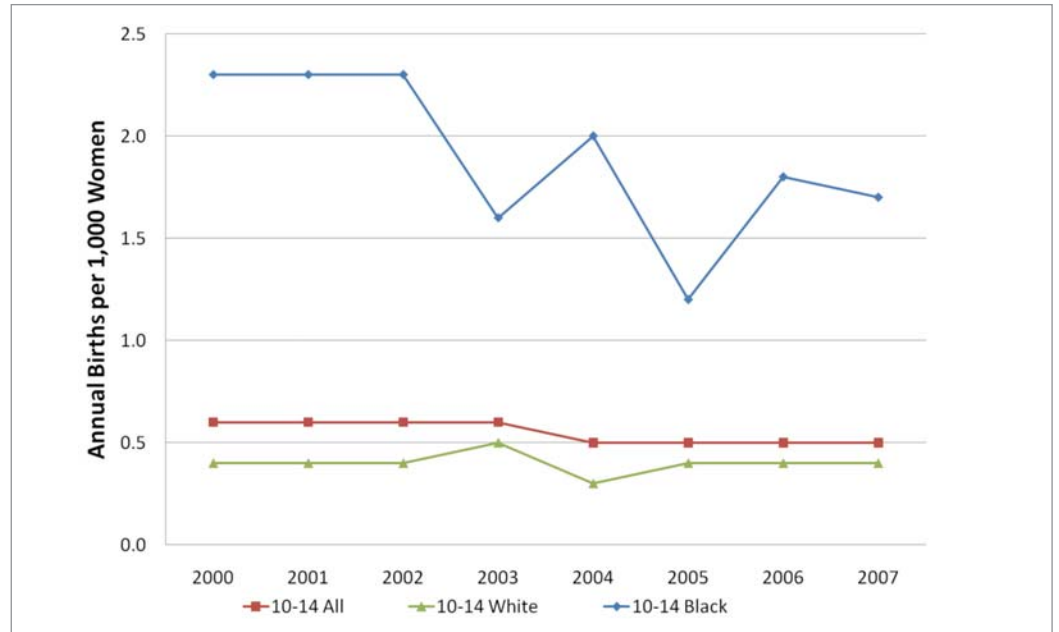
The U.S. teenage pregnancy rate is among the highest for industrialized nations (The Guttmacher Institute, 2002).. According to data from the National Center for Health Statistics, the 2004 teen pregnancy rate for Indiana women ages 15 to 19 (43.5 births per 1,000 women, annually) was higher than that for the nation (41.1 births per 1,000 women, annually) (National Center for Health Statistics, 2008). Furthermore, the National Campaign to Prevent Teen Pregnancy estimates that teen childbearing in Indiana cost taxpayers at least \$195 million in 2004 (The National Campaign to Prevent Teen Pregnancy, 2006). The majority of these costs are due to negative consequences for the children of teen mothers, and the cost is even greater for children of younger teens.

More recent ISDH data for Indiana indicate that the birth rate for women of all races ages 10 to 14 was 0.5 per 1,000 females in 2007, down from 1.1 per 1,000 in 1995 (see Figure 10). The annual birth rate for white girls ages 10 to 14 was 0.4 per 1,000, while that for black girls of the same age was 1.7 per 1,000.

The birth rate for women of all races ages 15 to 19 was 45.1 per 1,000 females in 2007, down from 57.2 per 1,000 in 1995 (see Figure 11), but an increase over more recent years. The birth rate for white women ages 15 to 19 was 41.5 per 1,000, while that for black women of the same age was 80.0 per 1,000.

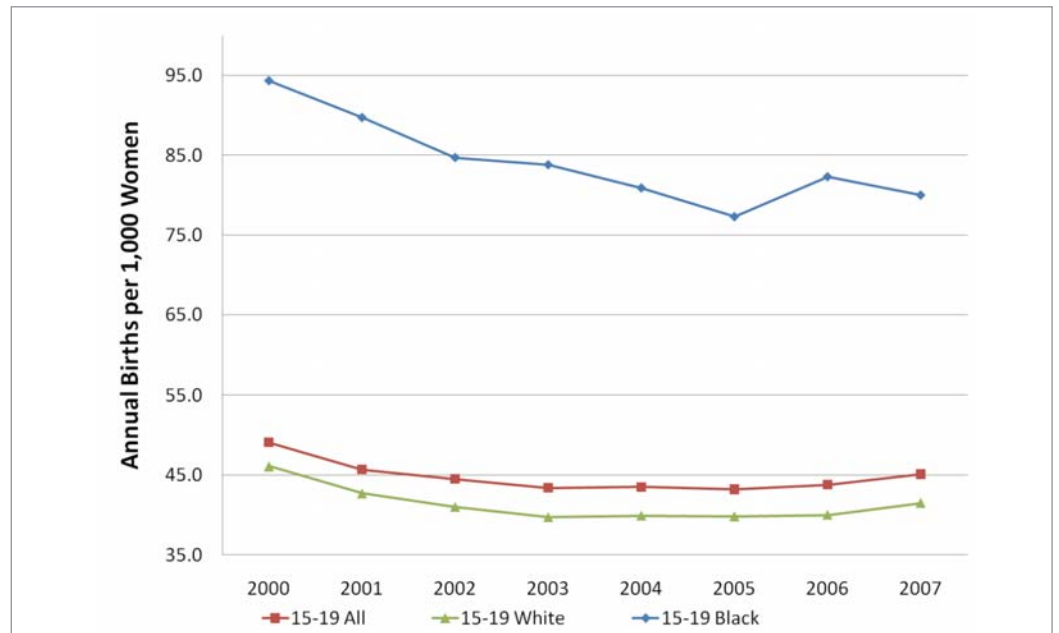


Figure 10: Birth Rates for Indiana Women Ages 10 to 14, by Race



Source: ISDH

Figure 11: Birth Rates for Indiana Women Ages 15 to 19, by Race



Source: ISDH



EARLY CHILDCARE RESOURCES, SUPPORT, AND DEVELOPMENT

To create a coordinated and accessible early childhood system, quality resources and supports must be fully integrated. This section assesses quality standards and examines the effectiveness of the ECCS initiative with regard to childcare resources, available supports, and educational development opportunities.

Licensed Childcare Facilities

Licensed childcare facilities in the State of Indiana are required to meet certain minimum standards in order to remain licensed, thus assuring the quality of these facilities. The number of licensed facilities and the overall licensed capacity provide one measure of the availability of childcare.

The Family and Social Service Administration's Bureau of Child Care (BCC) reported 3,057 licensed homes and 606 licensed childcare centers in state fiscal year 2009. These figures represent a licensed capacity of approximately 100,456 children, with a capacity of 62,394 at the licensed childcare centers and a capacity of 38,062 at licensed homes. Head Start programs that are licensed (either because they are full time or because they choose to be licensed) are included in the count of licensed capacity. The total licensed capacity could serve up to 19 percent of all Indiana children ages 5 and younger, a small decrease from the 20 percent of children as of February 2008.

Additional children could be cared for in ministry-based childcare facilities, which are not subject to licensing. While not subject to licensing, ministry-based care must meet minimum requirements for sanitation and fire and life safety. The capacity of unlicensed, registered childcare ministries is not reported.

Data from the BCC determines the number and percentage of Child Care Development Fund (CCDF) enrollees who are cared for in licensed childcare centers or homes. The CCDF is a federal fund helping needy families to obtain childcare so that parents can work or pursue training or education. During state fiscal year 2008, a total of 57,346 children were served by the CCDF. Of those children, 71.1 percent were enrolled in a licensed childcare setting, while the remaining 28.9 percent received services from a ministry- or faith-based day care setting (Indiana Family and Social Services Administration, 2008).

The BCC began implementing a statewide quality rating system called Paths to QUALITY on October 1, 2007. This rating system is a strategy to improve the quality of early childcare and education and to aid parents in selecting a high-quality early care and education provider. The program was validated by a Purdue University evaluation of the two pilot programs in the Fort Wayne and Evansville areas. The study concluded that: "If implemented with diligence, care, and accountability, the PTQ (Paths to QUALITY) program has the potential to increase the quality in child care centers, child care ministries, and child care homes in Indiana."

Head Start Programs can also participate in Paths to QUALITY. Childcare providers can enroll in Paths to QUALITY by contacting their local Child Care Resource and Referral (CCRR) office. Providers first attend an introductory session where they learn about the Paths to QUALITY requirements and incentives for participating. Next the provider signs a Paths to QUALITY agreement. Participants then are able to advance



through the levels with the help of a mentor if they choose. Participants must have their level verified every year.

The Paths to QUALITY program, funded by quality improvement targeted funds from the Child Care and Development Block Grant Program, had its rollout in January 2008. The program features a simple system to identify the level of care offered by a provider. The levels are:

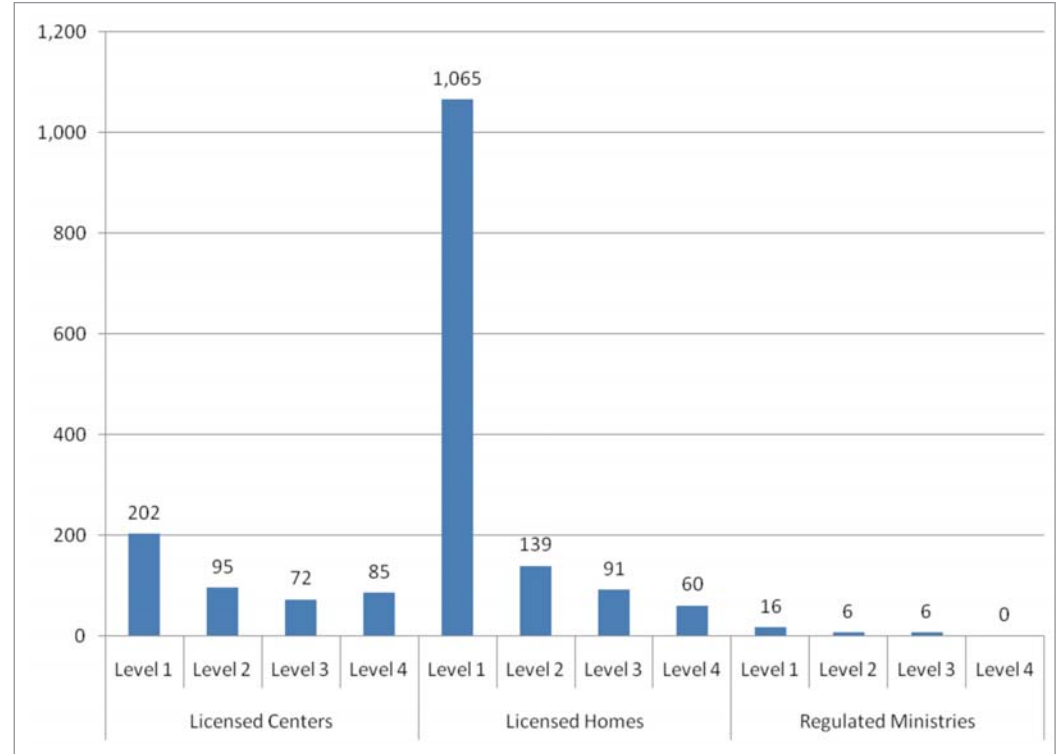
- Level 1 – health and safety needs of children are met.
- Level 2 – the environment supports children’s learning.
- Level 3 – a planned curriculum guides child development and school readiness.
- Level 4 – National accreditation has been achieved.

More information regarding Paths to QUALITY can be found at:

<http://www.childcarefinder.in.gov>

At the January ECCSS Core Partners Meeting, Melanie Brizzi, the Child Care Administrator with the Indiana FSSA, indicated that the Paths to QUALITY program has continued to exceed its enrollment goals. The most recent Paths to QUALITY enrollment report was released in April 2010. A total of 1,837 providers are participating in Paths to QUALITY, encompassing a combined capacity of 68,390 children. Figure 12 shows participation in Paths to QUALITY broken down by type of day care (licensed centers, licensed homes, and regulated ministries) and by level of participation.

Figure 12: Level of Participation in Paths to QUALITY by Type of Day Care (April 2010)



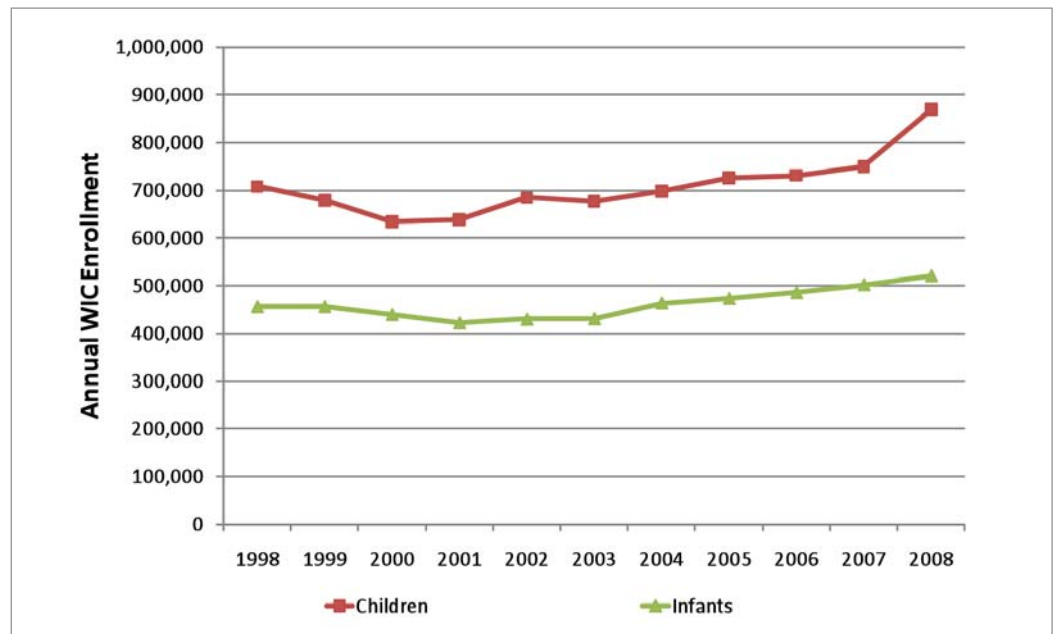


Special Nutrition Program for Women, Infants, and Children

For parents to quickly and effectively address their child's health, safety, and developmental needs, families must have access to resources that enable them to fulfill their children's basic needs. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) assists families in meeting their children's nutritional needs by providing food vouchers and nutritional education to pregnant women, infants, and children up to age 5.

According to the U.S. Department of Agriculture, the Indiana WIC program served an average of 155,761 individuals each month during FFY 2008 (see Figure 13)¹⁴ (United States Department of Agriculture, 2008). The ISDH reports that the Indiana WIC program served an average of 43,326 infants per month in 2008 (a 3.6 percent increase from the average of 41,809 infants served per month in 2007) and served an average of 72,513 children between 1 and 5 years of age during state fiscal year 2008 (a 16 percent increase from the 62,511 children served in 2007) (Thomas, 2009).

Figure 13: Average Monthly Enrollment by Year in the Special Supplemental Nutrition Program for Women, Infants, and Children



Source: Indiana State Department of Health

¹⁴October 2007–September 2008.



Early Childcare Information and Resources

Research shows that increased parental involvement in childcare is correlated with better outcomes for the children. Despite the positive outcomes associated with increased parental involvement, some parents remain unwilling or unable, due to stress and/or fear, to get involved because of a lack of information regarding their child's care (Coyne, 1995). One of the ECCS's objectives is to provide parents with information about their child's development to help them overcome any stresses and fears they may feel and encourage them to become more involved. This is an important step in improving the wellbeing of Indiana children because parents, with close daily contact with their children, can potentially recognize symptoms of delayed progression earlier than a physician.

To provide families of young children with a single comprehensive guide to available resources throughout the state and in their community, the ECCS initiative established an information clearinghouse. This clearinghouse, known as the Early Childhood Meeting Place (ECMP, <http://earlychildhoodmeetingplace.indiana.edu>) is maintained by the Indiana Institute on Disability and Community at Indiana University (IDC). The ECMP web site has recently been revised based on feedback from users of the site; the new site will be launched in summer of 2010. The ECMP web site houses a vast array of information, including 134 community resources, 66 childcare and early education resources, 127 health and safety resources, and 292 parenting and family resources.

Visits to the Family Section of the ECMP web site have been tracked since July of 2006; however, due to the

compromising of the site, no visit data is available from December 2007 to September 2008. Before the compromising of the sites' visit data, the number of visits showed steady growth from only 324 visits during July 2006 to 2,277 visits during November 2007. The main exception to steady growth in this period was a spike to 7,095 during June 2007. This spike in the number of visitors is likely due to an ad for the ECMP web site in the *Indianapolis Star* that summer; it may also have been due to the distribution of promotional materials for the ECMP in the spring of that year. To further increase awareness of the ECMP clearinghouse, promotional displays were distributed to doctors' offices.

As mentioned before, the number of visits from December 2007 through September 2008 is unknown because someone tampered with the ECMP web site. IDC staff believes this event is responsible for the high level of October 2008 visits as those who tampered with the site were probably attempting to do so again before finally giving up. For the months in late 2008 and early 2009 for which we have data, the number of unique visitors and the number of visits are similar to the levels at the end of 2007. Visits have grown sporadically across 2009 and early 2010.

Starting in February 2009, a number of Financial Resources Fact Sheets have been available on the ECMP web site. A total of 13,809 fact sheets were downloaded from February 2009 to May 2010, with downloads peaking at 1,410 downloads in March 2009, when there were a high number of visits to the Family Section of the ECMP. While downloads have not surpassed this peak yet, they are nearing this level with 1,180 downloads in March 2010 and 1,153 downloads in May 2010.



The ECMP website is currently being revised. The new version will be launched on July 1, 2010.

An additional source of information for parents of young children is the ECCS Developmental Calendar, *A Parent's Guide to Raising Healthy, Happy Babies*. This calendar contains advice for both parents and expecting parents and is available in both English and Spanish. The advice covers care suggestions for children from birth to age 5 and also provides space to record information about the child, such as doctor visits, growth charts, and immunization records. In addition, the guide includes a list of developmental benchmarks to aid parents in monitoring the development of their child and to assist in the identification of areas needing further attention from a doctor or nurse. In addition to the print versions, the calendar is also available electronically from the ECMP web site in both English and Spanish.

Also available from the ECMP web site are the Wellness Passport and the Special Health Care Needs Addendum, both of which are available in English and Spanish. The Wellness Passport is a tool to help families track medical information regarding their child in a format that can be easily shared with their medical

providers and the CSHCN Addendum which is designed for families whose children have complex healthcare needs that necessitate recording more specialized medical information

During the past year, the ECCS Evaluation Committee has worked on developing the foundation for a State of the Hoosier Child Report. To date, the committee has identified a list of indicators that will be included in the report. The indicators are grouped into the following categories (see Appendix C):

- Access to Healthcare and Medical Homes
- Social-Emotional Development and Mental Health
- Early Care and Education
- Parenting Education
- Family Support

Currently, the committee is locating data sources and determining measures for each indicator. Where possible the data is being gathered at the county level. All measures will be included in an annual State of the Hoosier Child Report. This report will track changes and compare the indicators over time and across locations, providing a snapshot of child wellbeing in Indiana and helping to identify areas for improvement.

CONCLUSION

The ECCS initiative seeks to improve the health and wellbeing of children in Indiana by ensuring continuity of care and by increasing parental involvement. The Core Partners, acting as the steering committee, have acted quickly to implement the changes necessary to achieve the objectives set forth in the ECCS initiative.

Some key accomplishments of the ECCS Project and its partners are:

- funding the ECMP web site, an information clearinghouse maintained by the Indiana Institute on Disability and Community at Indiana University, designed to provide families of young children with a single comprehensive guide to available resources throughout the state and in their community
- developing the ECCS Developmental Calendar, which contains advice for both parents and expecting parents in both English and Spanish versions
- developing several Financial Resources Fact Sheets, available in both English and Spanish on the ECMP web site
- launching Community Integrated Systems of Services for Children and Youth with Special Health Care Needs, which has as its major objective the development of the medical home concept in Indiana
- sponsoring training to help mental health professionals gain expertise in the social and emotional development of young children, infants, and toddlers

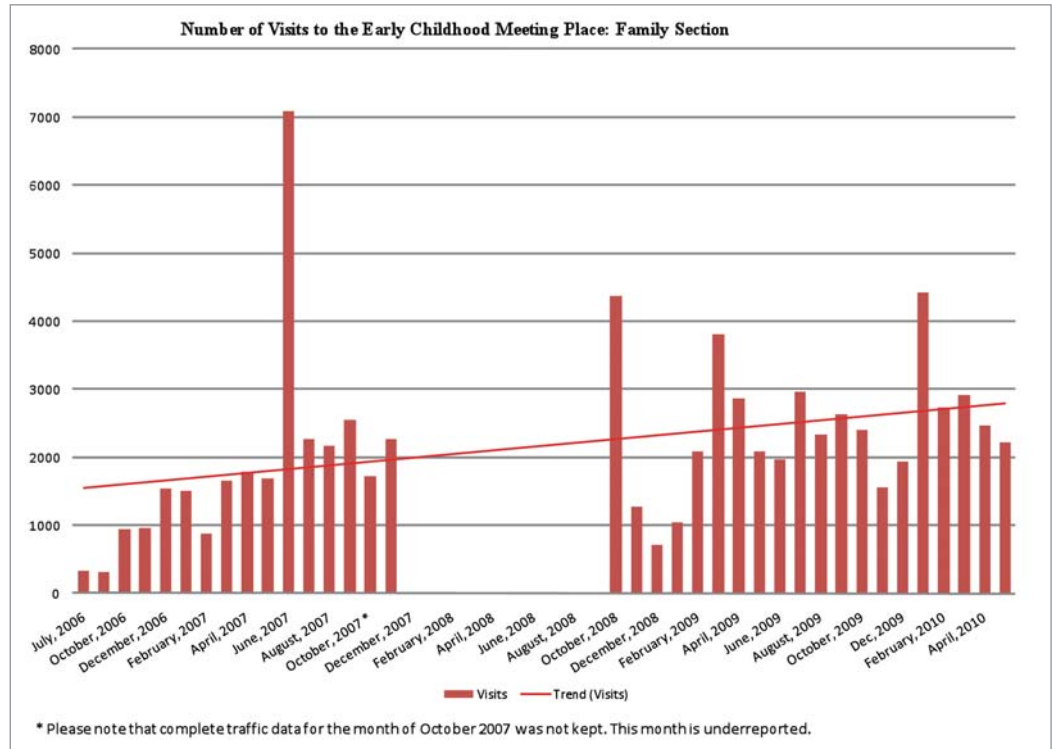
Areas identified for continued monitoring and where further progress is needed are:

- ***Use of dental care by children ages 1 through 5 is low.*** Children in this age group should be visiting the dentist

twice a year; however, according to the National Children's Health Survey only an estimated 53.8 percent of Indiana children ages 1 through 5 had one or more preventive dental care visits in the previous year. While this rate is better than the national rate of 53.5 percent, it is still very low. Dr. James Miller is the new director of Oral Health at ISDH and heads a task force that is currently addressing dental issues. Dr. Miller has over 25 years of experience including private practice, teaching, and dental public health. In addition to a D.D.S., Dr. Miller also holds a Ph.D. in epidemiology from the University of Washington (Severson, 2010). Dental care is one of the most requested topics on ISDH's Family Helpline.

- ***The number of children enrolled in the ISDH Children's Special Health Care Services (CSHCS) has decreased.*** In 2008, a total of 2,624 children ages 5 and younger participated in the CSHCS program, a decrease of 42 percent from the 4,538 children enrolled during 2002 (Indiana State Department of Health, 2009). This decrease is likely due to the removal of care coordinators from communities and a focus on case management with a yearly reevaluation of medical and financial eligibility. These rates will be tracked to determine if enrollment continues to decline.
- ***The capacity of licensed childcare facilities (both childcare centers and homes) is only sufficient to care for 19% of children 5 and younger in Indiana.*** This low capacity may be due to the fact that there are many unlicensed childcare facilities. Future reports will investigate the demand for childcare for children 5 and younger and will also seek any available data or estimates on the capacity of unlicensed childcare homes.

Appendix A: Visits to the Family Section of the ECMP Web Site





Appendix B: State of the Hoosier Child Indicators

Access to Health Care and Medical Homes

Measures of this indicator are:

- the percentage of pregnant women who receive prenatal care in the first trimester
- the percentage of children, birth to 5, who have health insurance coverage
- the percentage of children, birth to 5, who receive dental care
- the percentage of children, birth to 5, who receive immunizations appropriate to their age, development and medical status
- the percentage of newborns who are screened for hearing deficiencies and for the 29 metabolic disorders recommended by the March of Dimes

Social-Emotional Development and Mental Health

Measures of this indicator are:

- the percentage of pregnant and postpartum women who are screened for depression
- the percentage of children, birth to 5, who have experienced abuse, neglect or family violence and who subsequently receive a mental health screening
- the percentages of children, birth to 5, who have experienced abuse, neglect or family violence and who subsequently are referred to Early Intervention for evaluation
- the percentage of children, birth to five, who are expelled from their early childhood setting

Early Care and Education

Measures of this indicator are:

- the percentage of infants and toddlers who are enrolled in First Steps
- the percentage of preschoolers who are enrolled in preschool school special education

- the percentage of children, birth to 5, who are served in early care and education settings
- the percentage of families in need of child care whose children are enrolled in Paths to QUALITY sites
- the percentage of early childhood providers who have associates degrees or higher, and the percentage of early childhood providers with a CDA

Parenting Education

Measures of this indicator are:

- the percentage of families who access high-quality developmental screening
- the percentage of families with children, birth to 5, with Child Protective Services involvement
- the percentage of first time parents who are enrolled in Healthy Families
- the percentage of birthing hospitals that provide home visit post-delivery

Family Support

Measures of this indicator are:

- the percentage of children, birth to 5, who are involved in First Steps, Healthy Families, Early Head Start, Head Start, Even Start, or Early Childhood Special Education
- the percentage of eligible families with children, birth to 5, who are accessing heating assistance
- the percentage of families with children, birth to 5, where English is the second language
- the percentage of families with children, birth to 5, who are at or below the federal poverty level
- the percentage of families with children, birth to 5, who are not adequately housed (homeless)



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